



# MARYLAND Department of Health

## PREAUTHORIZATION REQUEST FORM PHYSICIAN SERVICES

### SECTION I- PATIENT INFORMATION

MEDICAID NUMBER (11 DIGIT)		TELEPHONE
NAME (LAST, FIRST, MI)		ADDRESS
DOB	SEX	

### SECTION II- PROVIDER INFORMATION

PAY TO PROVIDER # (9 DIGIT)		RENDERING PROVIDER # (9 DIGIT)	
NAME		NAME	
ADDRESS		ADDRESS	
TELEPHONE		TELEPHONE	
PROVIDER SIGNATURE			
Contact information for person completing this form:			
NAME		EMAIL	PHONE

### SECTION III- PREAUTHORIZATION INFORMATION

REQUEST DATE	DATES OF SERVICES: FROM	THRU
DIAGNOSIS CODES: 1.	2.	3.

### SECTION IV- PREAUTHORIZATION LINE ITEM INFORMATION

CODE	MOD 1	MOD 2	REQUESTED UNITS	DEPARTMENT USE ONLY

### SECTION V- SPECIFIC PROGRAM PREAUTHORIZATION INFORMATION

PLEASE ATTACH CORRESPONDENCE WHICH INCLUDES BUT IS NOT LIMITED TO THE FOLLOWING:
A. COMPLETE NARRATIVE JUSTIFICATION FOR PROCEDURE(S)
B. BRIEF HISTORY AND PHYSICAL EXAMINATION
C. RESULT OF PERTINENT ANCILLARY STUDIES IF APPLICABLE
D. PERTINENT MEDICAL EVALUATIONS AND CONSULTATIONS IF APPLICABLE

PREAUTHORIZATION NUMBER (DEPARTMENT USE ONLY)

### SUBMISSION INSTRUCTIONS:

Fax completed form and all required attachments to:  
1-410-767-6034.